PRINTED: 07/16/2009 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUII		E CONSTRUCTION	(X3) DATE S COMPL	
		09G141	B. WIN	ю		06/2	16/200 9
NAME OF P	PROVIDER OR SUPPLIER			143	ET ADDRESS, CITY, STATE, ZIP CO 3 NORTHGATE ROAD, NW SHINGTON, DC 20012	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
W 000	A recertification su 25, 2009 through J initiated using the frandom sample of a resident population disabilities. The findings of the observations, internand at two day proclient and administ incident reports. 483.430(e)(1) STA The facility must prinitial and continuing employee to perfore efficiently, and communications.	rvey was conducted from June une 26, 2009. The survey was fundamental survey process. A three clients was selected from on of six women with various survey were based on views with staff in the home grams, as well as a review of rative records, including FF TRAINING PROGRAM covide each employee with a training that enables the rm his or her duties effectively, apetently.	W 0		HEALTH REGULATI 825 NORTH CAPITOL	DISTRICT OF CONTROL OF CONTROL OF HEALTH	TION
	Based on observat review, the facility fremployee was provide training that enable or her duties effection competently. The findings including the finding the	ion, interview and record failed to ensure that each vided with initial and continuing do the employee to perform his invely, efficiently, and e: ne facility's Qualified Mental sional (QMRP) on June 26, and review of the training at the physical therapist trained by 2009. At the time of the ne facility failed to ensure direct ectively trained to teach Client ake informed choices about			W189 All staff were in serv the use of adaptive ed (Chest Harness) on in (#3) Wheel chair	quipment	7/06/09
LABORATOR	PRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	JU	TITLE .		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		09G141	B. WIN	1G _		06/2	6/2009
METRO I	ROVIDER OR SUPPLIER			14	REET ADDRESS, CITY, STATE, ZIP CODE 433 NORTHGATE ROAD, NW VASHINGTON, DC 20012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
W 189		ge 1 mess for her safety. [See	W-	189	W189 In the future the QMRP will		
W 356	483.460(g)(2) COM TREATMENT The facility must entreatment services needed for relief of restoration of teeth, health.	sure comprehensive dental that include dental care pain and infections, and maintenance of dental s not met as evidenced by:	w:	356	that all staff are trained in saprecautions and adaptive equipment and that the Resi Coordinator will monitor stadaily.	dential	
	Based on interview failed to ensure con services necessary health for one of the included in the sam The finding includes	and record review, the facility nprehensive dental treatment for the maintenance of dental e three clients (Client #1) ple.					
	2009 at 2:10 PM redated January 26, 2 reflected that the dewith large deposits a surfaces of her teet indicated that the clipoor. Scaling was a performed after auticlient returned to the 2009 and May 4, 2009.	's medical record on June 26, vealed a dental consultation 2009. The dental consult entist had diagnosed the client of plaque and calculus on all h. Additionally, the consult ient's oral hygiene was very recommended to be horization was obtained. The e dentist's office on March 31, 109, and was informed that ed the preauthorization for the			W356 In the future the QMRP and Nursing staff will ensure the dental recommendation is completed on a timely man see attached dentist statem.	nat nner.	7/08/09
	revealed adult propi performed, however	sultation dated June 6, 2009, hylaxis with polishing was r, the recommendation for the mouth scaling continued not			•		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE S COMPLE	
		09G14 1	B. WII			08/2	6/2009
NAME OF P	ROVIDER OR SUPPLIER			14	EET ADDRESS, CITY, STATE, ZIP CODE 133 NORTHGATE ROAD, NW /ASHINGTON, DC 20012		<u>u.2008</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 436	Interview with the fa Nurse (LPN) on Jurfacility had been ex getting preauthorize According to the nu process of finding a meantime, Client # again by the same of the su ensure Client #1's of 483.470(g)(2) SPACThe facility must fur and teach clients to choices about the unhearing and other cand other devices is	acility's Licensed Practical ne 26, 2009, revealed the periencing difficulty with ation for dental services. rse, the facility was in the mother dentist, but in the was scheduled to be seen dentist in September 2009. Arvey, the facility failed to lental health was maintained. DE AND EQUIPMENT was and to make informed se of dentures, eyeglasses, communications aids, braces,	W 4				
	Based on observation review, the facility fat taught to use and to about the use of the interdisciplinary teal.	s not met as evidenced by: on, interview and record alled to ensure clients was ornake informed choices devices identified by the m as needed by the client for Client #3) included in the					
	The finding includes	S .			W436		
	approximately 10:30 arriving at her day p	nt #3 on June 26, 2009 at OAM, revealed the client rogram. The client was Ichair being accompanied into			Refer to W189		

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII	ULTIPLE CONSTRUCTION DING		3) DATE SURVEY COMPLETED
		09G141_	B. WIN	G		06/26/2009
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, 9 1433 NORTHGATE RO WASHINGTON, DC	AD, NW	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRE CROSS-REFEREI	PLAN OF CORRECTIO CTIVE ACTION SHOULD NCED TO THE APPROP DEFICIENCY)	BE COMPLETION
W 436	an open space are revealed the client wheelchair seatbel adaptive equipmer. Review of Client #2009 at 4:33 PM, rdated May 2009. Crevealed the client harness/seat belt for Observation throug 2009 and June 26, wearing the recommenterview with som June 26, 2009, revicient wearing a chother staff had no lient wheelchair seatbel adaptive equipment.	a. Further observation wore molded shoes, had her it secured, but no other it was observed. 3's medical record on June 26, evealed a physician's order Continued review of the order required the use of a chest or safety. ghout the survey on June 25, 2009 revealed Client #3 not mended chest harness. e of the direct care staff on ealed that they had seen the est harness sometimes, and knowledge of the harness.	W	36		
	Professional (QMR that Client #3 had a the QMRP indicate wearing the chest when the facility's paraining. Continued the aforementioned that she spoke with day of the survey to regarding the client According to the Quinformed her that Cochest harness at a safety. At the time of the state of	Qualified Mental Retardation (P) on June 26, 2009 revealed a chest harness. Additionally, and that she recalled the client harness on June 19, 2009, physical therapist conducted dinterview with the QMRP on the did date, at 4:52 PM revealed in the physical therapist on the did ascertain information to the east and the physical therapist client #3 should be wearing the lill times as ordered for her survey, the facility failed to #3 safety harness was as prescribed.		W436 Refer to V	W189	

FORM APPROVED Health Regulation Administration STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING HFD03-0104 06/26/2009 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1433 NORTHGATE ROAD, NW **METRO HOMES** WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 1000 INITIAL COMMENTS 1000 A licensure survey was conducted from June 25, 2009 through June 26, 2009. A random sample of three clients was selected from a resident population of six women with various disabilities. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports. 1 206 3509.6 PERSONNEL POLICIES 1206 Each employee, prior to employment and annually thereafter, shall provide a physician 's certification that a health inventory has been performed and that the employee's health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that each employee, prior to employment and annually thereafter, provided evidence of a physician's certification 1206 that documented a health inventory had been performed and that the employee's health status In the future the OMRP and would allow him or her to perform the required duties for six of the ten records reviewed. HR Department will ensure 7/10/09 that all employee records are The findings include: updated according to policy. Interview with the Qualified Mental Retardation Professional (QMRP) on May 1, 2009, at 5:42 PM See attached health

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

and review of the personnel records revealed that

Certificate

the GHMRP failed to provide evidence that

Health Regulation Administration

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTI	PLE CONSTRUCTION G	COMP	LETED
		HFD03-0104		B. WING _		06	/26/200 9
NAME OF P	ROMDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
METRO I	HOMES			RTHGATE RESTON, DC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENCE)	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETE DATE
1206	direct care staff and	icates were on file for three consultants.		I 206			
I 229	fimited to, the follow (f) Specialty areas a residents to be sento, behavior manag recreation, total contechnologies; This Statute is not Based on observation review, the facility for equipment for one of (Client #3) The finding includes Interview with the the Retardation Profess 2009 at 4:52 PM arrecords verified that the staff on June 19	am shall include, but ving: related to the GHMR ved including, but not ement, sexuality, nut munications, and as met as evidenced by ion, interview and recailed to ensure staff in the area of adaptive of three clients in the	P and the ilimited crition, ssistive cord was e sample. Mental ne 26, ng ist trained of the	1 229	W1229		
I 40 1	#3 to use and to ma wearing a chest had Federal Citation W4	ctively trained to tead ake informed choices mess for her safety. 436] ON SERVICES: GEN	s about [Also see	i 401	Refer to	W189	
	•						<u>.</u>

03H811

06/26/2009

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

A BUILDING

(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED

HFD03-0104 B. WING _____

STREET ADDRESS, CITY, STATE, ZIP CODE

METRO HOMES 1433 NORTHGATE ROAD, NW WASHINGTON, DC 20012

NAME OF PROVIDER OR SUPPLIER

METRO HOMES		WASHINGTON, DC 20012				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PREGULATORY OR LSC IDENTIFYING INFORMATION OF LIFE IDENTIFYING INFORMATION O	FULL PREFIX	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
I 401	Continued From page 2	i 401				
	Professional services shall include both of and evaluation, including identification of developmental levels and needs, treatmes services, and services designed to prevedeterioration or further loss of function by resident.	ent				
	This Statute is not met as evidenced by: Based on interview and record review, the failed to ensure comprehensive dental transervices necessary for the maintenance health for one of the three residents (Res. #1) included in the sample.	e facility eatment of dental				
	The finding includes:					
	Review of Resident #1's medical record of 26, 2009 at 2:10 PM revealed a dental consultation dated January 26, 2009. The consult reflected that the dentist had diagonal the resident with large deposits of plaque calculus on all surfaces of her teeth. Additionally the consult indicated that the resident's of hygiene was very poor. Scaling was recommended to be performed after authorization was obtained. The resident returned to the dentist's office on March 3 and May 4, 2009, and was informed that not received the preauthorization for the statement of the second s	t t 2009 they had				
	Another dental consultation dated June 6 revealed adult prophylaxis with polishing performed, however, the recommendatio resident to receive full mouth scaling connot to be addressed.	was in for the	W1401 Refer to	W356		
	Interview with the facility's Licensed Prac Nurse (LPN) on June 26, 2009, revealed facility had been experiencing difficulty with	the				

03H811

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER (X1) PROVIDER/SUPPLIER/			A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		HFD03-0104				06/2	6/2009		
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 33 NORTHGATE ROAD, NW					
METRO	HOMES			RTHGATE R GTON, DC 2					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X6) COMPLETE DATE		
1 401	Continued From pa	ge 3		1 401					
:	getting preauthorize According to the nu process of finding a meantime, Residen seen again by the s 2009.	ation for dental services, the facility was in another dentist, but in at #1 was scheduled came dentist in September 1, the facility failed controls.	n the 1 the to be ember						
	ensure Resident #1 maintained.	's dental health was							

Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING B. WING HFD03-0104 06/26/2009 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1433 NORTHGATE ROAD, NW **METRO HOMES** WASHINGTON, DC 20012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) R 000 INITIAL COMMENTS R 000 A licensure survey was conducted from June 25. 2009 through June 26, 2009. A random sample of three clients was selected from a resident population of six women with various disabilities. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports. R 125 4701.5 BACKGROUND CHECK REQUIREMENT R 125 The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within R 125 which the prospective employee or contract In the future the OMRP and worker had worked or resided within the seven (7) years prior to the check for four of ten House Manager will ensure personnel files reviewed. that all employee records are also on filed in the home. The finding includes: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the GHMRP's See attached Criminal personnel records on June 26, 2008, beginning at Background report 5:42 PM revealed that the GHMRP failed to dated 02/09/06 provide evidence that criminal background

TITI E

03H811

Health Regulation Administration

STATE FORM

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIER REPRESENTATIVE'S SIGNATURE

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIE IDENTIFICATION NU	R/CLIA MBER:	(X2) MULTI A. BUILDIN B. WING _	PLE CONSTRUCTION G			
NAME OF P	ROVIDER OR SUPPLIER	1	STREET AD	DRESS, CITY, 8	STATE, ZIP CODE		*******	
METRO	HOMES		1433 NOT WASHING	RTHGATE ROSTON, DC 20	OAD, NW 0012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
R 125		e and disclosed a sev risdictions where the		R 125	DEFICIENT			

Health Regulation Administration